HIE Steering Committee

Claims Pilot Subcommittee

Meeting #5 – May 28, 2021

Agenda

- Review New Use Cases: Green Mountain Care Board (GMCB)
- Next Steps

Role of Subcommittee Members Re: Use Cases

- Learn about each of the use cases presented by fellow subcommittee members
  - *What is the user trying to accomplish? How does this relate to or inform my use cases?*
- Weigh in: support editing, culling, prioritizing
  - *How could this be augmented to be clearer? Is it missing anything? Where does this fit in your sense of priorities?*
- Support assessment of technical feasibility by VITL and MMIS partners

Use Case Categories - Definition

- Clinical uses – Individual:
  - These use cases focus **on how data/information is used in a clinical setting to support clinical decisions** made **between an individual and their provider**.

- QI/operational - Organization:
  - These use cases focus **on how data is used by an organization** and can be grouped into two categories. 1) How a health care organization uses data **to improve its processes/workflow** and improve panel management for groups of patients. 2) How a program uses data **to enhance operations** such as setting payment levels for value-based payments or making policy decisions on how the program operates.

- Evaluation – Population health:
  - These use cases focus on whether a program, policy, or intervention achieved what it meant to achieve. The **outcomes are used to support decision making**; can be more dynamic and flexible that reporting, though often rely on similar nationally recognized measures; see below.

- Reporting – Population Health:
  - These use cases are **measures** often agreed upon at the beginning of a program/ agreement/demonstration **to be monitored by an overseeing entity**, e.g., the federal government. Generally, these **measures are drawn from nationally recognized measures**.

Use Case Review

USE CASE: QI/Operations - Organization

Defining more precise scope of a Health Care Organization (e.g., Provider landscape)

USER STORY

Actors: GMCB Analytical Staff
Recipient: GMCB and Regulated Entities (e.g., Hospitals)

As an Analyst for GMCB,
I need to use integrated Clinical & Claims Data,
So that I can support the GMCB primary responsibilities which include but not limited to:

- Review Hospital Budgets annually
- Review Health Insurance Premium Rates annually for certain products
- Review Certificate of Needs (build infrastructure for the State) which can be approved by the GMCB.
- ACO Budget Review (Regulatory Duty)

A key component is having a more accurate picture of the Providers and Services provided as well as their financial relationships within a Health Care Organization e.g., Hospitals.

USE CASE: QI/Operations - Organization

Defining more precise scope of a Health Care Organization (e.g., Provider landscape)

ORGANIZATIONS

1. Green Mountain Care Board (GMCB) is an independent body made up of five board members and support staff charged with several regulatory duties e.g., Hospital Budget Review, Administering All Payer Model
2. GMCB does not produce the Claims Data.
3. GMCB uses Claims Data, and they are Stewards of Health Care Database (Manages VHCURES) as well as other Health Care Data

CHALLENGES/PAIN POINTS

1. GMCB has access only to Claims Data.
2. Pain points:
   a) GMCB is limited in a way to assess the value of a Health Care Organization due to lack of access to integrated Clinical & Claims Data
   b) GMCB is limited in understanding Health Care Organizations from a Clinical Lens
   c) Identity management is a pain point for GMCB because the Claims data comes to GMCB in a de-identified format (not in clear text, but hashed string)

GOAL

1. GMCB would like to measure Clinical component Value instead of Cost.
2. How well GMCB can assess the Claims Data.
3. Hoping to understand the successful Health Outcomes (e.g., Provider quality for knee replacement surgery) using Clinical Data (Electronic Health Record) and Patient assessment reports.
4. Assessing Clinical quality of Care particularly at the Hospital level, if possible
5. Using the integrated Clinical & Claims Data to define the Health Care Organization
6. Build Longitudinal Health Record using Hospital discharge record data, which is by episode.
7. Clinical data alone might not be enough. Aggregated Clinical & Claims data at Personal/patient Level in VHIE will be helpful

TRADING PARTNERS AND SYSTEMS

1. Systems:
   a) Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)
   b) Vermont Uniform Hospital Discharge Data System (VUHDDS)
   c) Hospital financial information through ADAPTIVE, a software application
   d) Tableau, a data visualization tool
   e) Statistical software – R, Python, STSS, ARCGIS
2. Organizations (Partners):
   a) DVHA Medicaid
   b) Vermont Department of Health (VDH)
   c) Commercial Payers
   d) Hospitals
   e) Accountable Care Organization (ACO)
   f) Centers for Medicare & Medicaid Services (CMS)
   g) OnPoint Health Data (Vendor)
   h) VAHHS NSO (Vendor)

DATA TO EXCHANGE

1. Information to be exchanged:
   a) Claims - Medical & Pharmaceutical
   b) Eligibility Information (Health Insurance Coverage of Individual)
   c) Provider Information (Rendering and Billing)
   d) Hospital Discharge Records
   e) Hospital financial information
   f) ACO Network and financial information
2. Types of data needed:
   a) Results associated with the Patient Records that are not billed for, in the Claims.
   b) Attributes of patients like BMI, Language Spoken & Written, Race, Ethnicity etc.
   c) Screenings and other services that were not billed for, in Clinical records.

DATA GOVERNANCE

1. Vermont Statutes
2. Data Governance Council
3. HIPAA
4. Data Use Agreements with DVHA & CMS
5. State GMCB Rules

FREQUENCY

Annually, at a minimum
Currently GMCB gets Claims data from VHCURES Quarterly.

USE CASE TARGET DATE

When available

MMIS DATA PIPELINE

MMIS provides the Data extract to DVHA Data Team.
DVHA Data Team provides this Data to VHCURES which is then passed to GMCB.

DATA FORMAT (Source to VHIE)

Preferably Real Time. If that is not an option, then timely data extracts as agreed between the parties.

TRANSPORT MECHANISM

GMCB will work with the available Transport mechanism.

DATA RECIPIENT FORMAT (VHIE to End User)

TBD with technical team.

CONSENT SPECIFICATIONS

1. Consent is not an issue, as the data is in de-identified format at GMCB.
2. If in future, the Data is identified at personal level, applicable Consent(s) will need to be considered.

LEGAL AGREEMENTS

1. If in future, the Data is identified at personal level, required Legal Agreements must be considered.

Evaluation of Provider Quality

USER STORY

Actors: GMCB Regulatory staff

Recipient: GMCB and Regulated Entities (e.g., Hospitals)

As a Regulatory Staff at GMCB,

I need to use integrated Clinical & Claims Data,

So that I can support the Board's Regulatory Authority to:

1. Set criteria and goals for value-based Payment Models.
2. Develop and measure value through Payment Reforms to better support the health of Vermonters.

USE CASE: Evaluation - Population

Evaluation of Provider Quality

ORGANIZATIONS

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DATA GOVERNANCE

1. Vermont Statutes
2. Data Governance Council
3. HIPAA
4. Data Use Agreements with DVHA & CMS
5. State GMCB Rules
6. Proprietary limitations and anti-trust considerations for competing entities

FREQUENCY

Annually, at a minimum, more frequently will be helpful. Currently GMCB gets Claims data from VHCURES Quarterly.

USE CASE TARGET DATE

By 2024, as a new Payer Model with the Federal Govt. is expected to start.

MMIS DATA PIPELINE

MMIS provides the Data extract to DVHA Data Team. DVHA Data Team provides this Data to VHCURES which is then passed to GMCB.

DATA FORMAT (Source to VHIE)

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TRANSPORT MECHANISM

GMCB will work with the available Transport mechanism.

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Discussion/Feedback

Debrief on Use Case Gathering Process

- What did you do to prepare?
- What helped you successfully participate in the process?
- What went well?
- What can be improved?
- What should others expect?

Use Cases Summary

	Category	Use Case Name	Stakeholder
1	Clinical - Individual	Prescription Reconciliation, Fulfillment Monitoring	Mary Kate Mohlman
2	Clinical - Individual	Validate the Service Provided	Mary Kate Mohlman
3	QI/Operations - Organization	Panel Management of Individuals with Chronic Conditions– identifying those whose conditions need better management	Mary Kate Mohlman
4	Evaluation - Population	Assessing Quality Improvement Initiatives on Hypertension Control and Outcomes	Mary Kate Mohlman
5	Reporting - Population	Percent of population with Hypertension in control and Diabetes in poor control	Mary Kate Mohlman
6	QI/Operations - Organization	Improving support and Care management for individuals with Hypertension and Diabetes in the State	Katelyn Muir
7	QI/Operations - Organization	Improve Immunization Rate	Katelyn Muir
8	Evaluation - Population	Evaluating the Clinical impact of the Care Coordination Model	Katelyn Muir
9	Evaluation - Population	Evaluation of primary prevention by Health Service Areas (HSA)	Katelyn Muir
10	QI/Operations – Organization	Determine payments made to providers participating in Medicaid value-based payment arrangements.	Pat Jones Erin Flynn
11	Reporting - Population	AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting	Pat Jones Erin Flynn

Use Cases Summary

	Category	Use Case Name	Stakeholder
12	Clinical – Individual	Help inform Care Management Functions	James Mauro
13	QI/Operations – Organization	Identify Members for Integrated Health Programming including Risk Stratification	James Mauro
14	Evaluation - Population	Evaluate the performance of a Healthcare Reform/Payment Reform Program	James Mauro
15	QI/Operations – Organization	Development of a Healthcare Reform/Payment Reform Program	James Mauro
16	Reporting - Population	Conduct quality reporting that requires clinical data without relying on manual medical chart extractions	James Mauro
17	QI/Operations – Organization	Clinical data to support Utilization Management Program	James Mauro
18	QI/Operations - Organization	Defining more precise scope of a Health Care Organization (e.g., Provider landscape)	Sarah Lindberg
19	Evaluation - Population	Evaluation of Provider Quality	Sarah Lindberg

Next Steps

- Complete the remaining (two) use case gathering sessions in June [*see slide 15 for more details*]
- Prioritize the use cases
- Evaluate the subcommittee's work and identify remaining gaps

Use Case Gathering Sessions

#	Interview	Focus of Discussion	Schedule & Status
1	**Katie Muir**, *OneCare VT*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/3/2021 – Completed**
2	**Pat Jones**, *DVHA Payment Reform* **Erin Flynn**, *DVHA Payment Reform*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/30/2021 – Completed**
3	**Ben Green**, *Blue Cross Blue Shield* **James Mauro**, *Blue Cross Blue Shield*	• Commercial Claims	**4/19/2021 – Completed**

4	**Sarah Lindberg**, *Green Mountain Care Board*	• Analytics for -
		  • evaluating the APM
		  • evaluating the Boards regulatory activities
			5/10/2021 – Completed

5	**Emma Harrigan**, *VAHHS* **Lauri Scharf**, *BiState Primary Care Assoc.* **Thomasena E Coates**, *Blueprint QI Facilitator*	• Point of care support	**6/1/2021 – Scheduled**
6	**Lisa Schilling**, *Medicaid Operation* **Erin Carmichael**, *Medicaid Quality* **Shawn Skaflestad**, *Medicaid Performance Management/Improvement* **Tim Tremblay**, *Vermont Blueprint for Health*	• Quality Improvement and Reporting for Medicaid and the Blueprint • Overall evaluation of GC1115 waiver	**6/10/2021 – Scheduled**